

		FOR OHF USE					

LL 1

2003
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2003)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: <u>0037077</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER	
Facility Name: <u>Holly Hill</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/03</u> to <u>12/31/03</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.	
Address: <u>203 Lafayette</u> <u>Anna</u> <u>62906</u> Number City Zip Code		Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.	
County: <u>Union</u>		Officer or Administrator of Provider (Signed) _____ (Date) _____	
Telephone Number: <u>(618) 833-3322</u> Fax # <u>(618) 833-4993</u>		(Type or Print Name) <u>Richard Stroh</u>	
IDPA ID Number: <u>37-1272695001</u>		(Title) <u>Asst. Comptroller</u>	
Date of Initial License for Current Owners: <u>09/07/91</u>		(Signed) _____ (Date) _____	
Type of Ownership:		Paid Preparer (Print Name and Title) _____	
<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____		(Firm Name & Address) _____ (Telephone) <u>()</u> Fax # ()	
<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input checked="" type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____		MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630	
GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____			
In the event there are further questions about this report, please contact: Name: <u>Richard Stroh</u> Telephone Number: <u>(618) 833-5070</u>			

STATE OF ILLINOIS

Page 2

Facility Name & ID Number Holly Hill# 0037077 Report Period Beginning: 01/01/03 Ending: 12/31/03

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed beds5840

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6	<u>16</u>	ICF/DD 16 or Less	<u>16</u>	<u>5,840</u>	6
7	<u>16</u>	TOTALS	<u>16</u>	<u>5,840</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD	<u>5,178</u>	<u>365</u>		<u>5,543</u>	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>5,178</u>	<u>365</u>		<u>5,543</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 94.91%

D. How many bed-hold days during this year were paid by Public Aid?

61 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)None

F. Does the facility maintain a daily midnight census?

YesG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐ NO ☒

I. On what date did you start providing long term care at this location?

Date started 01/01/91

J. Was the facility purchased or leased after January 1, 1978?

YES ☒ Date 01/01/91 NO ☐

K. Was the facility certified for Medicare during the reporting year?

YES ☐ NO ☒ If YES, enter number
of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 12/31/03 Fiscal Year: 12/31/03

* All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS

Page 3

Facility Name & ID Number

Holly Hill

0037077

Report Period Beginning:

01/01/03

Ending:

12/31/03

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	37,741	1,223	1,272	40,236		40,236		40,236		1
2	Food Purchase		36,165		36,165		36,165		36,165		2
3	Housekeeping	16,486	4,224	1,230	21,940		21,940	73	22,013		3
4	Laundry		989		989		989		989		4
5	Heat and Other Utilities			12,936	12,936		12,936	187	13,123		5
6	Maintenance		3,182	1,827	5,009		5,009	3,878	8,887		6
7	Other (specify):*										7
8	TOTAL General Services	54,227	45,783	17,265	117,275		117,275	4,138	121,413		8
	B. Health Care and Programs										
9	Medical Director			3,600	3,600		3,600		3,600		9
10	Nursing and Medical Records	138,118	2,202	1,980	142,300	(138)	142,162	841	143,003		10
10a	Therapy			4,946	4,946		4,946		4,946		10a
11	Activities		482	618	1,100		1,100		1,100		11
12	Social Services		620	1,724	2,344		2,344	(620)	1,724		12
13	Nurse Aide Training			692	692	138	830		830		13
14	Program Transportation			2,711	2,711		2,711		2,711		14
15	Other (specify):* Day Training			151,261	151,261		151,261	(151,261)			15
16	TOTAL Health Care and Programs	138,118	3,304	167,532	308,954		308,954	(151,040)	157,914		16
	C. General Administration										
17	Administrative	17,677		4,800	22,477		22,477	5,034	27,511		17
18	Directors Fees										18
19	Professional Services			24,899	24,899		24,899	(23,897)	1,002		19
20	Dues, Fees, Subscriptions & Promotions			2,705	2,705		2,705	(51)	2,654		20
21	Clerical & General Office Expenses		2,208	6,726	8,934		8,934	7,642	16,576		21
22	Employee Benefits & Payroll Taxes			30,012	30,012		30,012	3,598	33,610		22
23	Inservice Training & Education			240	240		240		240		23
24	Travel and Seminar			129	129		129	65	194		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			3,792	3,792		3,792	295	4,087		26
27	Other (specify):*										27
28	TOTAL General Administration	17,677	2,208	73,303	93,188		93,188	(7,314)	85,874		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	210,022	51,295	258,100	519,417		519,417	(154,216)	365,201		29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Holly Hill

#0037077

Report Period Beginning:

01/01/03

Ending:

12/31/03

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			14,103	14,103		14,103	10,850	24,953			30
31	Amortization of Pre-Op. & Org.			75	75		75		75			31
32	Interest			12,025	12,025		12,025		12,025			32
33	Real Estate Taxes			5,801	5,801		5,801	110	5,911			33
34	Rent-Facility & Grounds			36,000	36,000		36,000	(35,520)	480			34
35	Rent-Equipment & Vehicles			90	90		90		90			35
36	Other (specify):*											36
37	TOTAL Ownership			68,094	68,094		68,094	(24,560)	43,534			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			29,814	29,814		29,814		29,814			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			29,814	29,814		29,814		29,814			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	210,022	51,295	356,008	617,325		617,325	(178,776)	438,549			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

Facility Name & ID Number Holly Hill

0037077

Report Period Beginning:

01/01/03

Ending:

12/31/03

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$ (151,261)	15	\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(534)	22		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	9,973	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(15)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule Sum - Pg. 5A	(717)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (142,554)		\$	30

OHF USE ONLY						
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(36,222)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (36,222)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (178,776)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

Holly Hill

ID# 0037077

Report Period Beginning: 01/01/03

Ending: 12/31/03

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	PAC Dues	\$ (77)	20	1
2	Diapers	(20)	10	2
3	Flowers	(170)	12	3
4	Clothing	(159)	12	4
5	Christmas Gifts	(291)	12	5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(717)		49

Summary A

12/31/03

12/31/03

[illegible]

Summary B

12/31/03

12/31/03

[illegible]

Facility Name & ID Number Holly Hill# 0037077

Report Period Beginning:

01/01/03

Ending:

12/31/03

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
<u>Don J. Pippins</u>	<u>50</u>	<u>Glen Brook</u>	<u>Vienna</u>	<u>kel-Tech</u>	<u>Anna</u>	<u>Mgmt Co</u>
<u>Christian D. Pippins</u>	<u>50</u>	<u>Liberty House</u>	<u>Marion</u>	<u>JR Centre</u>	<u>Anna</u>	<u>DT Program</u>
		<u>Krypton</u>	<u>Metropolis</u>	<u>ILS 1-3</u>	<u>Anna</u>	<u>CILA</u>
		<u>Colonial Manor</u>	<u>Ziegler</u>	<u>ILS 4</u>	<u>Metropolis</u>	<u>CILA</u>
		<u>Pilot House</u>	<u>Cairo</u>			
		<u>Lincoln Square</u>	<u>Jonesboro</u>			
		<u>Mulberry Manor & New Way Inc.</u>	<u>Anna</u>			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	3 <u>Housekeeping</u>	\$	<u>kel-Tech Management Co.</u>	<u>25.00%</u>	\$ <u>73</u>	\$ <u>73</u>	1
2	V	5 <u>Utilities</u>		<u>kel-Tech Management Co.</u>	<u>25.00%</u>	<u>187</u>	<u>187</u>	2
3	V	6 <u>Maintenance</u>		<u>kel-Tech Management Co.</u>	<u>25.00%</u>	<u>601</u>	<u>601</u>	3
4	V	19 <u>Legal & Accounting</u>		<u>kel-Tech Management Co.</u>	<u>25.00%</u>	<u>103</u>	<u>103</u>	4
5	V	20 <u>Dues, Fees & Subscriptions</u>		<u>kel-Tech Management Co.</u>	<u>25.00%</u>	<u>41</u>	<u>41</u>	5
6	V	21 <u>Clerical & General Office</u>		<u>kel-Tech Management Co.</u>	<u>25.00%</u>	<u>1,242</u>	<u>1,242</u>	6
7	V	22 <u>Employee Benefits</u>		<u>kel-Tech Management Co.</u>	<u>25.00%</u>	<u>4,132</u>	<u>4,132</u>	7
8	V	24 <u>Training</u>		<u>kel-Tech Management Co.</u>	<u>25.00%</u>	<u>65</u>	<u>65</u>	8
9	V	26 <u>Insurance</u>		<u>kel-Tech Management Co.</u>	<u>25.00%</u>	<u>295</u>	<u>295</u>	9
10	V	30 <u>Depreciation</u>		<u>kel-Tech Management Co.</u>	<u>25.00%</u>	<u>877</u>	<u>877</u>	10
11	V	33 <u>Real Estate Taxes</u>		<u>kel-Tech Management Co.</u>	<u>25.00%</u>	<u>110</u>	<u>110</u>	11
12	V	34 <u>Building Lease</u>		<u>kel-Tech Management Co.</u>	<u>25.00%</u>	<u>480</u>	<u>480</u>	12
13	V							13
14	Total		\$			\$ <u>8,206</u>	\$ * <u>8,206</u>	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number **Holly Hill**# **0037077**Report Period Beginning: **01/01/03**Ending: **12/31/03****VII. RELATED PARTIES (continued)**

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	10 Nursing Wages	\$	kel-Tech Management Co.	25.00%	\$ 861	\$ 861	15
16	V	17 Administrative Wages		kel-Tech Management Co.	25.00%	5,034	5,034	16
17	V	21 Clerical Wages		kel-Tech Management Co.	25.00%	6,400	6,400	17
18	V	6 Maintenance Wages		kel-Tech Management Co.	25.00%	3,277	3,277	18
19	V	19 Professional Services	24,000	kel-Tech Management Co.			(24,000)	19
20	V	34 Building Lease	36,000	J & J Partners			(36,000)	20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 60,000			\$ 15,572	\$ * (44,428)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

STATE OF ILLINOIS

Page 7

Facility Name & ID Number Holly Hill # 0037077 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Don J. Pippins	Adm/Owner	Accounting/ Mgmt	50.00	74,346	1	2.50	ADM	\$ 11,677	17	1
2	Christian D. Pippins	Adm/Owner	Prog/ Mgmt.	50.00		4	10.00	ADM/QMRP	32,800	10	2
3	Diana Alley	DON	DON		25,866	4	10.00	RN	11,679	10	3
4											4
5											5
6											6
7	kel-Tech Mgmt Allocations										7
8	Diana Alley							Nursing	861		8
9	Jacob Alley							Maintenance	3,277		9
10	James A. Keller							ADM	4,214		10
11	Don J. Pippins							ADM	820		11
12											12
13								TOTAL	\$ 65,328		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME.
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Holly Hill# 0037077

Report Period Beginning:

01/01/03Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization kel-Tech Management Co.Street Address 158 E. Vienna StreetCity / State / Zip Code Anna, IL 62906Phone Number (618) 833-5070Fax Number (618) 833-4993

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	3	HOUSEKEEPING	Mgmt. Fee Contribution	360,366	12	\$ 1,089	\$ 24,000	\$ 73	1
2	6	UTILITIES	Mgmt. Fee Contribution	360,366	12	2,809	24,000	187	2
3	6	MAINT.-VEHICLES	Mgmt. Fee Contribution	360,366	12	135	24,000	9	3
4	6	MAINT.BUILDING	Mgmt. Fee Contribution	360,366	12	150	24,000	10	4
5	6	MAINT.SUPPLIES	Mgmt. Fee Contribution	360,366	12	179	24,000	12	5
6	6	GROUNDS MAINT.	Mgmt. Fee Contribution	360,366	12	663	24,000	44	6
7	6	REPAIRS-VEHICLES	Mgmt. Fee Contribution	360,366	12	1,577	24,000	105	7
8	6	REPAIRS-BUILDINGS	Mgmt. Fee Contribution	360,366	12	179	24,000	12	8
9	6	REPAIRS	Mgmt. Fee Contribution	360,366	12	2,231	24,000	149	9
10	6	TRANSPORTATION	Mgmt. Fee Contribution	360,366	12	3,910	24,000	260	10
11	19	LEGAL & ACCOUNTING	Mgmt. Fee Contribution	360,366	12	1,540	24,000	103	11
12	20	DUES,FEES,SUBSCRIPTIONS	Mgmt. Fee Contribution	360,366	12	608	24,000	41	12
13	21	G & A SUPPLIES	Mgmt. Fee Contribution	360,366	12	8,490	24,000	565	13
14	21	POSTAGE	Mgmt. Fee Contribution	360,366	12	3,094	24,000	206	14
15	21	SOFTWARE EXP.	Mgmt. Fee Contribution	360,366	12	1,922	24,000	128	15
16	21	TELEPHONE	Mgmt. Fee Contribution	360,366	12	2,914	24,000	194	16
17	21	TELEPHONE CELL	Mgmt. Fee Contribution	360,366	12	1,040	24,000	69	17
18	21	PRINTING	Mgmt. Fee Contribution	360,366	12	52	24,000	3	18
19	21	COPIER EXPENSE	Mgmt. Fee Contribution	360,366	12	1,137	24,000	76	19
20	22	PAYROLL TAX EXPENSE	Mgmt. Fee Contribution	360,366	12	19,692	24,000	1,311	20
21	22	INS.-EMPLOYEE GROUP	Mgmt. Fee Contribution	360,366	12	39,811	24,000	2,651	21
22	22	INSURANCE-W/C	Mgmt. Fee Contribution	360,366	12	2,534	24,000	169	22
23	24	STAFF TRAINING	Mgmt. Fee Contribution	360,366	12	334	24,000	22	23
24									24
25	TOTALS				\$ 96,090	\$		\$ 6,399	25

Facility Name & ID Number Holly Hill# 0037077

Report Period Beginning:

01/01/03Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization kel-Tech Management Co.Street Address 158 E. Vienna StreetCity / State / Zip Code Anna, IL 62906Phone Number (618) 833-5070Fax Number (618) 833-4993

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	24 SEMINAR	Mgmt. Fee Contribution	360,366	12	\$ 646	\$	24,000	\$ 43	1
2	26 INSURANCE-VEHICLES	Mgmt. Fee Contribution	360,366	12	811		24,000	54	2
3	26 INSURANCE-BLDG. & LIAB.	Mgmt. Fee Contribution	360,366	12	3,652		24,000	243	3
4	30 DEPRECIATION	Mgmt. Fee Contribution	360,366	12	13,162		24,000	877	4
5	33 REAL ESTATE TAXES	Mgmt. Fee Contribution	360,366	12	1,656		24,000	110	5
6	34 LEASE-Building	Mgmt. Fee Contribution	360,366	12	7,200		24,000	480	6
7	10 NURSING WAGES	Mgmt. Fee Contribution	360,366	12	12,928	12,928	24,000	861	7
8	17 ADMINISTRATION WAGES	Mgmt. Fee Contribution	360,366	12	75,589	75,589	24,000	5,034	8
9	21 CLERICAL WAGES	Mgmt. Fee Contribution	360,366	12	96,097	96,097	24,000	6,400	9
10	6 MAINTENANCE WAGES	Mgmt. Fee Contribution	360,366	12	49,201	49,201	24,000	3,277	10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 260,941	\$ 233,815		\$ 17,379	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	Anna State Bank		X	Remodeling	\$292.60	8/12/99	\$ 20,000	\$	9/5/03	9.0000	\$ 469	1	
2	Anna National Bank		X	Remodeling	\$2,400.69	11/5/99	200,000	136,303	11/5/09	7.7830	11,246	2	
3	Ford Credit		X	Van Purchase	\$685.18	4/3/01	22,896	2,039	4/3/04	4.8970	310	3	
4												4	
5												5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related				\$3,378.47		\$ 242,896	\$ 138,342			\$ 12,025	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$ 242,896	\$ 138,342			\$ 12,025	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ N/A Line #

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

Facility Name & ID Number **Holly Hill**# **0037077** Report Period Beginning: **01/01/03** Ending: **12/31/03****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2002 report.		\$ 5,800	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$ 5,741	2
3. Under or (over) accrual (line 2 minus line 1).		\$ (59)	3
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)		\$ 5,860	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$ 5,801	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	1998 4,139	8	
	1999 4,188	9	
	2000 4,300	10	
	2001 5,720	11	
	2002 5,741	12	
Sch. IX, Line 7 \$5801			
Kel-Tech Mgmt Allocation 110			
Sch. V, Line33 Col. 8 5911			
		FOR OHF USE ONLY	
	13	FROM R. E. TAX STATEMENT FOR 2002 \$	13
	14	PLUS APPEAL COST FROM LINE 5 \$	14
	15	LESS REFUND FROM LINE 6 \$	15
	16	AMOUNT TO USE FOR RATE CALCULATION \$	16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Holly Hill COUNTY Union

FACILITY IDPH LICENSE NUMBER 0037077

CONTACT PERSON REGARDING THIS REPORT Richard Stroh

TELEPHONE 618-833-5070 FAX #: 628-833-4993

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2002.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>14-00-08-178</u>	<u>E. PT Lot 8 W Davies 1st Add</u>	\$ <u>263.88</u>	\$ <u>263.88</u>
2. <u>14-00-08-179</u>	<u>Lot 9 W Davies 1st Add</u>	\$ <u>5,477.42</u>	\$ <u>5,477.42</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>5,741.30</u></u>	\$ <u><u>5,741.30</u></u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES x NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

A. Square Feet:

3,600

B. General Construction Type:

Exterior

Wood

Frame

Wood

Number of Stories

2

C. Does the Operating Entity?

☐

(a) Own the Facility

☒

(b) Rent from a Related Organization.

☐

(c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?

☒

(a) Own the Equipment

☐

(b) Rent equipment from a Related Organization.

☐

(c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐

YES

☒

NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Healthcare	3,600	1991	\$ 5,000	1
2					2
3	TOTALS	3,600		\$ 5,000	3

Facility Name & ID Number Holly Hill

0037077

Report Period Beginning:

01/01/03

Ending:

12/31/03

XL OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	16		1984	1984	\$ 126,386	\$	25	\$ 5,055	\$ 5,055	\$ 97,310	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Driveway Paving		1992	1992	2,500	148	15	125	(23)	1,986	9
10	Carpet		1996	1996	284		7	18	18	284	10
11	Improvements		1996	1996	765		7	56	56	765	11
12	Leaschold Improvements		1999	1999	196,342	5,034	39	7,854	2,820	20,346	12
13	Heating & Cooling System		1999	1999	2,486	166	15	124	(42)	1,079	13
14	Carpet		1999	1999	13,197	1,178	7	1,320	142	10,252	14
15	Security Alarm		1999	1999	470	42	7	47	5	365	15
16	Improvements		2000	2000	19,670	504	39	787	283	1,870	16
17	Carpet		2000	2000	2,086		7	209	209	2,086	17
18	Fire Alarm System		2000	2000	1,933		7	193	193	1,933	18
19	Stair Treads		2002	2002	253	43	7	36	(7)	144	19
20	Heating & Cooling System		2002	2002	2,239	149	15	149		899	20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$	\$		37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 368,611	\$ 7,264		\$ 15,973	\$ 8,709	\$ 139,319	70

**Improvement type must be detailed in order for the cost report to be considered complete.

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 1,355	\$ 232	\$ 193	\$ (39)	7	\$ 774	71
72	Current Year Purchases	1,251	1,251	145	(1,106)	7	1,251	72
73	Fully Depreciated Assets	22,000		2,186	2,186	7	22,000	73
74								74
75	TOTALS	\$ 24,606	\$ 1,483	\$ 2,524	\$ 1,041		\$ 24,025	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Healthcare	1984 Van	1984	\$ 13,383	\$	\$		5	\$ 13,383	76
77	Healthcare	2001 Van	2001	27,896	5,356	5,579	223	5	19,862	77
78										78
79										79
80	TOTALS			\$ 41,279	\$ 5,356	\$ 5,579	\$ 223		\$ 33,245	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 439,496	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 14,103	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 24,076	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 9,973	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 196,589	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$		86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Related Party

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

**

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized
by the length of the lease _____.

9. Option to Buy: ☐ YES ☐ NO Terms: _____ *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

☐ YES ☒ NO

16. Rental Amount for movable equipment: \$ 90

Description: Water Cooler

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. _____ \$ _____

13. _____ \$ _____

14. _____ \$ _____

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.	2. CLASSROOM PORTION: IN-HOUSE PROGRAM <input checked="" type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> COMMUNITY COLLEGE <input type="checkbox"/> HOURS PER AIDE <u>44</u>	3. CLINICAL PORTION: IN-HOUSE PROGRAM <input checked="" type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> HOURS PER AIDE <u>86</u>
---	--	---

B. EXPENSES

ALLOCATION OF COSTS (d)

		1 Facility		2	3	4
		Drop-outs	Completed	Contract	Total	
1	Community College Tuition	\$	\$	\$	\$	
2	Books and Supplies					
3	Classroom Wages (a)		281		281	
4	Clinical Wages (b)		548		548	
5	In-House Trainer Wages (c)					
6	Transportation					
7	Contractual Payments					
8	Nurse Aide Competency Tests					
9	TOTALS	\$	\$ 830	\$	\$ 830	
10	SUM OF line 9, col. 1 and 2 (e)	\$ 830				

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	2
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	2

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
 (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
 (c) For in-house training programs only. Do not include fringe benefits.
 (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
 (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8		
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service	Cost	Units	Cost					
					1	Licensed Occupational Therapist		hrs	\$		\$
	Licensed Speech and Language										
2	Development Therapist		hrs								2
3	Licensed Recreational Therapist		hrs								3
4	Licensed Physical Therapist		hrs								4
5	Physician Care		visits								5
6	Dental Care		visits								6
7	Work Related Program		hrs								7
8	Habilitation		hrs								8
9	Pharmacy		# of prescrpts								9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)										
10			hrs								10
11	Academic Education		hrs								11
12	Exceptional Care Program										12
13	Other (specify):										13
14	TOTAL			\$		\$	\$		\$		14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 27,057	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	115,249		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	884		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 143,190	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	242,223		15
16	Equipment, at Historical Cost	65,885		16
17	Accumulated Depreciation (book methods)	(99,279)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	440		19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 209,269	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 352,459	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 6,262	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	30		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	6,830		30
31	Accrued Taxes Payable (excluding real estate taxes)	2,259		31
32	Accrued Real Estate Taxes(Sch.IX-B)	5,860		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 21,241	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	2,039		39
40	Mortgage Payable	136,303		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 138,342	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 159,583	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ 192,876	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 352,459	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 164,764	1
2	Restatements (describe):		2
3	Rounding Error Priors Years	(1)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 164,763	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	28,113	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 28,113	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 192,876	24 *

* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 490,939	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 490,939	3
B. Ancillary Revenue			
4	Day Care	151,261	4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 151,261	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements	4,283	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 4,283	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Handling Fee Income</u>	19	28
28a	<u>Loss on Sale of Asset</u>	(1,064)	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ (1,045)	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 645,438	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	117,275	31
32	Health Care	308,954	32
33	General Administration	93,188	33
B. Capital Expense			
34	Ownership	68,094	34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee	29,814	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 617,325	40
41	Income before Income Taxes (line 30 minus line 40)**	28,113	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 28,113	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number **Holly Hill**# **0037077**Report Period Beginning: **01/01/03**

Ending:

12/31/03

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	507	507	\$ 11,845	\$ 23.36	1
2	Assistant Director of Nursing					2
3	Registered Nurses					3
4	Licensed Practical Nurses					4
5	Nurse Aides & Orderlies					5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants					10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor	1,737	1,915	17,813	9.30	13
14	Head Cook					14
15	Cook Helpers/Assistants	2,200	2,315	19,928	8.61	15
16	Dishwashers					16
17	Maintenance Workers					17
18	Housekeepers	2,036	2,119	16,486	7.78	18
19	Laundry					19
20	Administrator	302	302	17,677	58.53	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	2,083	2,124	33,500	15.77	28
29	Resident Services Coordinator	2,013	2,138	25,645	11.99	29
30	Habilitation Aides (DD Homes)	9,476	9,660	67,128	6.95	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	20,354	21,080	\$ 210,022 *	\$ 9.96	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	33	\$ 1,271	1-3	35
36	Medical Director	36	3,600	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	12	360	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	44	2,227	10-3	43
44	Activity Consultant				44
45	Social Service Consultant	52	1,673	12-3	45
46	Other(specify) <u>Psychologist Cons</u>	54	2,719	10-3	46
47	<u>Administrator Cons</u>	48	4,800	17-3	47
48	<u>Dental Cons</u>	11	1,100	10-3	48
49	TOTAL (lines 35 - 48)	290	\$ 17,750		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		\$		53

Facility Name & ID Number **Holly Hill**# **0037077**Report Period Beginning: **01/01/03**Ending: **12/31/03**

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
C. Denise Pippins	Administrator	50	\$ 17,677	Workers' Compensation Insurance	\$ 3,445	IDPH License Fee	\$ 1,000	
				Unemployment Compensation Insurance	1,523	Advertising: Employee Recruitment	119	
				FICA Taxes	16,155	Health Care Worker Background Check		
				Employee Health Insurance	8,245	(Indicate # of checks performed <u>6</u>)	72	
				Employee Meals	534	Kel-Tech Mgmt Allocation	41	
				Illinois Municipal Retirement Fund (IMRF)*		Vehicle Lic./Resid. Bond/Adm Lic.	367	
				Staff Meals	(534)	Buying Club Membership	130	
				Misc. Employee Benefits	110	IHCA Membership	864	
				Kel-tech Mgmt Allocation	4,132	IHCA PAC/Contributions	92	
						Subscriptions	61	
						Less: Public Relations Expense	(92)	
						Non-allowable advertising	()	
						Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 17,677	TOTAL (agree to Schedule V, line 22, col.8)	\$ 33,610	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 2,654	
(List each licensed administrator separately.)								
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees				
Description			Amount	Description	Line #	Amount		
Administrator Consultant			\$ 4,800					
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 4,800					
(Attach a copy of any management service agreement)								
C. Professional Services				G. Schedule of Travel and Seminar**				
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	
F.M.G.R.	Legal		104				Out-of-State Travel	
Barnett & Levine	Accounting		795					
Kel-Tech Mgmt Co	Acct/Mgmt		24,000				In-State Travel	
							Seminar Expense	
							Kel-Tech Allocation	
							Seminar	
							Entertainment Expense	
							(agree to Sch. V, line 24, col. 8)	
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL		\$		
(If total legal fees exceed \$2500 attach copy of invoices.)			\$ 24,899				\$ 194	

* Attach copy of IMRF notifications

**See instructions.

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

[illegible]

Facility Name & ID Number **Holly Hill**

STATE OF ILLINOIS

0037077

Report Period Beginning:

01/01/03

Ending:

Page 23

12/31/03

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. IHCA \$864 PAC \$77
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 5 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 20 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES x NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO x If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 29,814
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? N/A
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 534 Has any meal income been offset against related costs? No Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 100%
d. Have vehicle usage logs been maintained? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. Audit not required of this facility.
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.

Related Parties Schedule VII
Owners Compensation
Jan 1, 2003 - Dec 31, 2003

	Totals / Entity	Holly Hill	ILS 1-4	JR's Centre	Mulberry Manor	Pilot House	Liberty House	Lincoln Square	kel-Tech Mgmt	Krypton	Glen Brook	New Way
Don Pippins	\$ 127,149	\$ 11,677	\$ 7,177	\$ 22,015			\$ 6,000		\$ 11,934	\$ 42,037		\$ 26,309
Denise Pippins	\$ 117,203	32800	21518	62885								
Diana Alley	\$ 70,741	11679	23854	9342	14189			11677				
Jo Ann Keller	\$ 133,902			10462	99945	23495						
James K. Keller	\$ 24,474			10462	14012							
Jacob Alley	\$ 47,136								47136			
Jake Alley	\$ 16,297			16297								
James A. Keller	\$ 90,462		18015						61368		11079	
	\$ 627,364	\$ 56,156	\$ 70,564	\$ 131,463	\$ 128,146	\$ 23,495	\$ 6,000	\$ 11,677	\$ 120,438	\$ 42,037	\$ 11,079	\$ 26,309

Holly Hill, Inc.
Sch. V, Line 13, Col.5
2003

Transfer of \$138 from DSP/Nursing Wages to Training Wages.

Holly Hill, Inc.
Depreciation Reconciliation
2003

Book Depreciation	\$ 14,103.00	\$ 14,103.00
Straight Line Depreciation	24,076.00	
Adjustment to S/L Depreciation		9,973.00
Sch XI, E. Line 83		24,076.00
Kel-Tech Mgmt Depreciation		877.00
Sch V, Line 30, Column 8		<u>\$ 24,953.00</u>

Holly Hill, Inc
Reconciliation of Book and Tax Income
Year Ended December 31, 2003

Adjusted book income (loss)	\$28,113
Section 481(a) adjustment - reversal of accruals as of January 1, 2003	(89,403)
Adjustment for accrual changes from January 1, 2003 to December 31, 2003	(3,539)
Adjustment for non-deductible expenses:	
Contributions carryover	15
Section 179 carryover	<u>1,251</u>
	(63,563)
Add (Deduct) provision for federal income taxes payable (refundable)	<u>0</u>
Taxable income (loss) per federal income tax return	<u><u>(\$63,563)</u></u>